

STATEMENT OF CONSIDERATION RELATING TO  
907 KAR 9:015

Department for Medicaid Services  
Amended After Comments

(1) A public hearing regarding 907 KAR 9:015 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 9:015:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Kathy Adams, Director of Public Policy	Children's Alliance
Rebecca Randall, Director of Regulatory Affairs	WellCare
Sharon D. Perkins, Director of Health Policy	Kentucky Hospital Association

(3) The following individual from the promulgating agency responded to comments received regarding 907 KAR 9:015:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Leslie Hoffmann, Director	Department for Medicaid Services, Division of Community Alternatives
Ann Hollen, Program Manager	Department for Medicaid Services, Division of Community Alternatives
Jonathan MacDonald, Policy Analyst	Department for Medicaid Services, Commissioner's Office
Stuart Owen, Regulation Coordinator	Department for Medicaid Services, Commissioner's Office

SUMMARY OF COMMENTS AND AGENCY'S RESPONSES

(1) Subject: Billable non face-to-face encounter

(a) Comment: Kathy Adams, Director of Public Policy, Children's Alliance, stated the following:

"Page 8, line 11-12 Recommend that language be added to clarify that there are exceptions to (3) as (2)(a) indicates services that can be billed when there is not a face-to-face encounter. H0032 does not require the recipient to be present, but is a billable 15 minute unit code based upon the DMS Fee Schedule. Recommend that (3) be amended to read:

‘(3) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter, unless the service is exempt from a face-to-face encounter as provided in subsection (2)(a) of this Section.’”

(b) Response: The Department for Medicaid Services (DMS) is revising the language in an “amended after comments” administrative regulation as follows to address the service planning exception:

“(3) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter except for any component of service planning that does not require the presence of the recipient or recipient’s representative.”

(2) Subject: Treatment plan

(a) Comment: Kathy Adams, Director of Public Policy, Children’s Alliance, stated the following:

“Page 8, line 19-20 (5)(b) requires the “plan of care” (not a defined phrase) to meet the treatment plan requirements established in 902 KAR 20:320. Treatment plan requirements in 902 KAR 20:320 are specific to “inpatient” PRTF I or II services and not outpatient behavioral health services. The phrase used in 902 KAR 20:320 Section 14, which is specific to “outpatient behavioral health services” is plan of care. It does not seem appropriate for DMS to hold PRTF I or II outpatient behavioral health services to a “residential inpatient” PRTF I or II requirement. Recommend that (4) be amended to read:

(b) A plan of care shall meet the treatment plan of care requirements established in Section 14 of 902 KAR 20:320.”

(b) Response: DMS is revising the language in an “amended after comments” administrative regulation to replace the term “treatment plan” with “plan of care” and to refer to Section 14.

(3) Subject: Mobile crisis services requirement

(a) Comment: Kathy Adams, Director of Public Policy, Children’s Alliance, stated the following:

“Page 23, line 22-23 (3)(e)2. includes the following mobile crisis services requirement for a PRTF I or II that is not a requirement for BHSOs that provide mobile crisis services:

2. Ensure access to a board-certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days per week, every day of the year;

Why is this a requirement for a PRTF but not a BHSO?”

(b) Response: The requirement should have been stated in the BHSO administrative regulation but was inadvertently omitted.

(4) Subject: Service planning for a child

(a) Comment: Sharon D. Perkins, Director of Health Policy, Kentucky Hospital Association, stated the following:

“Page 32, line 22, (3)(m)2.a. and b. requires the service plan to be directed by the recipient and include practitioners of the recipient’s choosing. Recommend adding an exception to these requirements when the recipient is a child and the child is not old enough, mature enough or able (due to their current mental health or substance abuse issues) to direct the service plan and/or choose practitioners that would allow the recipient’s representative to perform these functions. Additionally, should there be a requirement for the involvement of a recipient’s representative in the service planning process when the recipient is a child?”

(b) Response: DMS is addressing the concern in an “amended after comments” administrative regulation with the following revised language:

“(m)1. Service planning shall:

a. Involve assisting a recipient in creating an individualized plan for services needed for maximum reduction of the effects of a mental health disorder;

b. Involve restoring a recipient's functional level to the recipient's best possible functional level; and

c. Be performed using a person-centered planning process.

2. A service plan:

a. Shall be directed by the:

(i) recipient; or

(ii) Recipient’s representative if the recipient is under the age of eighteen (18) years or is unable to provide direction;.”

(5) Subject: Reimbursement for same date of ACT services

(a) Comment: Sharon D. Perkins, Director of Health Policy, Kentucky Hospital Association, stated the following:

“(2) establishes that DMS will not bill or reimburse for a list of services provided “for the same date of service” for a recipient receiving assertive community treatment (ACT). Request clarification of this requirement since ACT is a monthly rate. Use of the phrase “same date of service” is confusing. Does this mean that none of the services listed in (2)(a) thru (f) will be reimbursed during a month when the recipient is receiving ACT services?”

(b) Response: DMS is clarifying the language in an “amended after comments”

administrative regulation. Indeed, none of the individual components of ACT will be covered during a month that ACT is provided as it would be a duplication of service. The revised language is:

“(2) For a recipient who is receiving assertive community treatment, the following shall not be billed or reimbursed for the same period of time in which the recipient receives assertive community treatment~~[date of service for the recipient]~~:

- (a) An assessment;
- (b) Case management;
- (c) Individual outpatient therapy;
- (d) Group outpatient therapy;
- (e) Peer support services; or
- (f) Mobile crisis services.”

(6) Subject: Prior authorization

(a) Comment: Rebecca Randall, Director of Regulatory Affairs, stated the following:

“The proposed regulation language states that “A behavioral health service established in Section 5 of this administrative regulation shall not be subject to prior authorization.” While WellCare does not dispute requiring prior authorization for screening and crisis intervention, we strongly disagree that intensive outpatient services should not require prior authorization. We respectfully request that this language be revised to reflect that prior authorization be required for intensive outpatient program services.”

Proposed language also states that mobile crisis services shall ensure 24/7 access to a board-certified or board-eligible psychiatrist physician. WellCare suggests that this same verbiage and requirement be added into the crisis stabilization units.”

(b) Response: DMS appreciates the different perspective but staff involved in developing the policies does not recommend prior authorization for the services. Managed care organizations are free to impose prior authorization requirements that differ from DMS’s requirements established for services to the “fee-for-service” population; thus, WellCare may impose prior authorization on intensive outpatient services if it so wishes.

(7) Subject: 24/7 access to a board-certified or board-eligible psychiatrist physician

(a) Comment: Rebecca Randall, Director of Regulatory Affairs, stated the following:

“Proposed language also states that mobile crisis services shall ensure 24/7 access to a board-certified or board-eligible psychiatrist physician. WellCare suggests that this same verbiage and requirement be added into the crisis stabilization units.”

(b) Response: Residential crisis stabilization unit (RCSU) services are not addressed in this administrative regulation but are addressed in 907 KAR 15:070. 907 KAR 15:070 is

not currently being revised.

SUMMARY OF STATEMENT OF CONSIDERATION  
AND  
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 9:015 and is amending the administrative regulation as follows:

Page 8

Section 2(3)

Line 12

After “encounter” insert the following:

except for any component of service planning that does not require the presence of the recipient or recipient’s representative

Page 8

Section 2(5)(b)

Line 19

After “the”, delete “treatment”.

After “plan” insert “of care”.

Line 20

After “20:320”, insert “, Section 14”

Page 26

Section 4(3)(g)1.a.

Line 10

After “provided”, delete “to a recipient”.

Page 29

Section 4(3)(i)1.a.

Line 17

After “the”, insert “recipient”.

Delete “individual”.

Page 29

Section 4(3)(i)1.b.

Line 18

After “b.”, insert “Recipient’s”.

Page 30

Section 4(3)(j)1.b.(i)

Line 11

After “the”, insert “recipient”.  
Delete “individual”.

Page 30  
Section 4(3)(j)1.b.(ii)  
Line 12  
After “(ii)”, insert “Recipient’s”.

Page 31  
Section 4(3)(k)3.a.(i)  
Line 22  
After “the”, insert “recipient”.  
Delete “individual”.

Page 31  
Section 4(3)(k)3.a.(ii)  
Line 23  
After “(ii)”, insert “Recipient’s”.

Page 32  
Section 4(3)(m)2.a.  
Line 22  
After “the”, insert a colon, a return, and “(i)”.

After “recipient”, insert the following:  
: or  
(ii) Recipient’s representative if the recipient is under the age of eighteen (18 years or is unable to provide direction

Page 33  
Section 4(3)(n)2.c.  
Line 17  
After “address”, insert “the recipient’s”.

Page 38  
Section 5(2)  
Line 1  
After “same”, insert the following:  
period of time in which the recipient receives assertive community treatment

Delete the following:  
date of service for the recipient

Page 40  
Section 7(3)(a)1.f.  
Line 22

After “f.”, insert “If applicable, the”.

Page 42

Section 7(5)(a)2.b.

Line 20

After “b.”, insert “Behavioral health practitioner’s”.

Delete “Therapist’s”.

Page 47

Section 7(14)(b)3.c.

Line 12

After “enrollee”, insert “the”.